ALABAMA MEDICAID AGENCY
LONG TERM CARE REQUEST FOR ACTION FORM

Provider's Name: _____

NPI Number: _____ **Provider's Area Code & Fax Number:** _____

Contact Person: _____ **Provider's Area Code & Phone Number:** _____

Waiver Type: _____ **County Number:** _____ **Center Number:** _____

Recipient's Name: _____ **Recipient's SSN or Medicaid Number:** _____

REASON FOR CORRECTING LONG TERM CARE FILE:

1. **Incorrect Medicaid Admission Date Requested:**

   Change Date From: _____ **Change Date To:** _____

2. **Incorrect Discharge or Death Date Requested:**

   Change Date From: _____ **Change Date To:** _____

3. **Retro Financial Eligibility Awarded:**

   Change Date From: _____ **Change Date To:** _____

REASON FOR REQUESTED CHANGE AND/OR EDS REJECTION REASON:

_____

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_____

FAX REQUEST TO: Alabama Quality Assurance Foundation (AQAF), (205) 970-1614.

FOR MEDICAID USE ONLY:

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Date Correction Made: _____ **Corrected By:** _____

Confidentiality Warning: This document is intended for the use of the individual or entity to which it is addressed. It may contain information that is privileged, confidential and exempt from disclosure pursuant to the Social Security Act, Health Insurance Portability and Accountability Act, Internal Revenue Act and other applicable laws. Disclosure of such information is subject to fines and other penalties. If you have received this communication in error, notify the Medicaid Agency immediately by telephone or fax. You should return the document with a notation that it was received in error.